OVERCOMING THAT "LONG DISTANCE" FEELING: STRATEGIES FOR PHYSICIAN RECRUITMENT AND RETENTION IN NORTHERN, RURAL AND UNDERSERVICED ONTARIO

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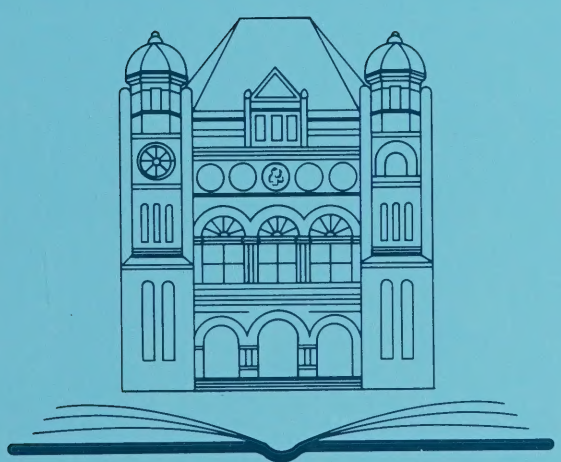

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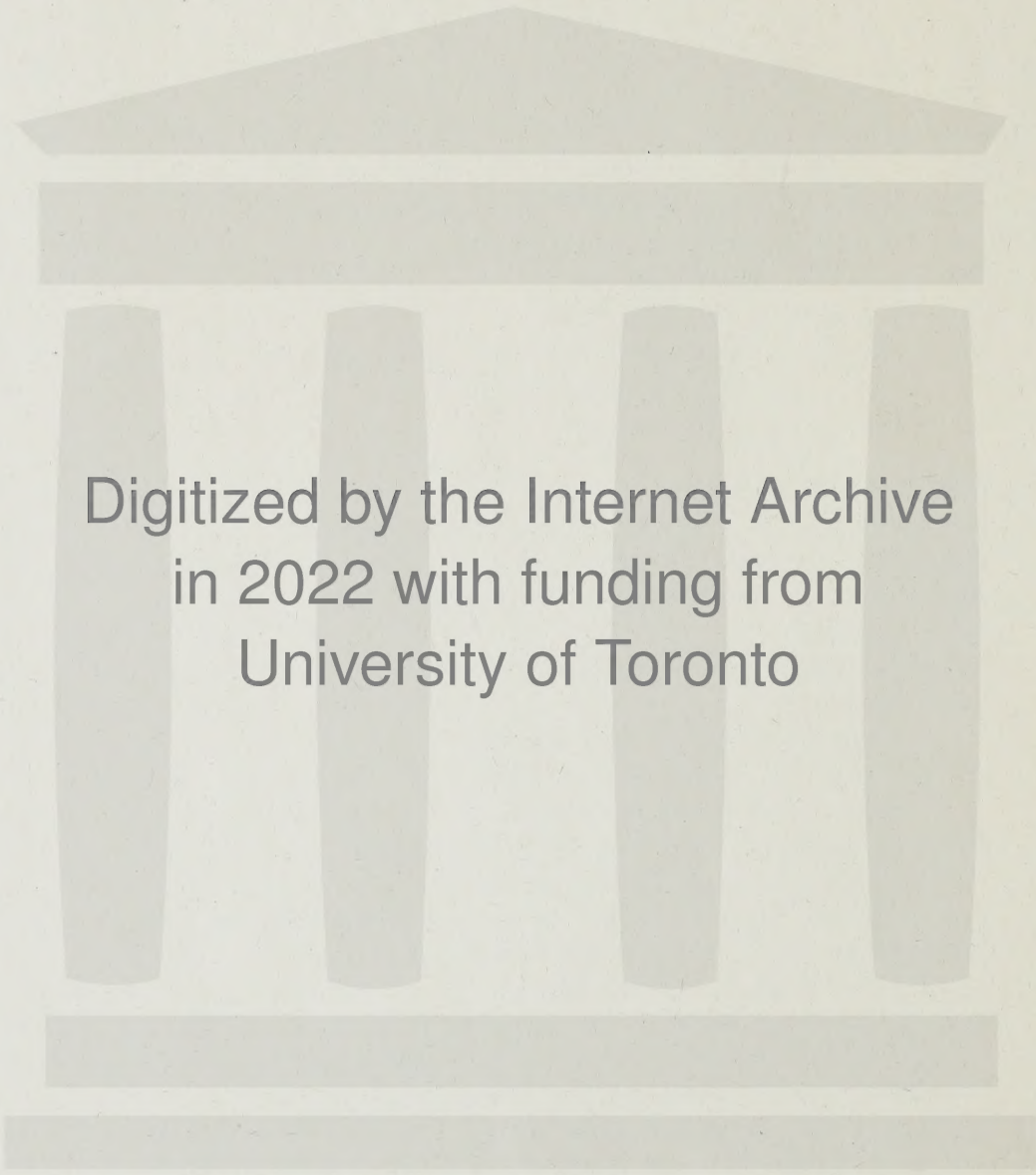

INTRODUCTION

In 1994, Opposition health critics, Members and Party Leaders in the Ontario Legislature made statements, asked questions and some even got themselves ejected from the chamber[1] over the contentious issue of providing adequate health care services in northern, rural and underserviced parts of Ontario. Of particular concern to Members and their constituents was the provision of emergency medical care in rural and northern hospitals,[2] the shortage of medical specialists,[3] and how to attract and retain physicians, surgeons and specialists in underserviced areas of Ontario.[4] According to the Ontario Ministry of Health, in 1994 about 130 physicians (from family doctors to psychiatrists) were urgently needed in rural communities across the province.[5]

In 1987 the Spasoff *Report of the Panel on Health Goals for Ontario* declared that "all residents of Ontario have the right to high quality, accessible, appropriate and comprehensive health services . . ."[6] At the same time, it acknowledged that residents of northern Ontario do not enjoy the same access to health care as people in southern Ontario, and must often travel to the south for specialized services.[7] Other reports such as *Operation Critical: The Report of the New Democratic Task Force on Northern Health Care Issues*,[8] and the Ontario Medical Association's (OMA) Reports on the *Northern Health Travel Grant Program*[9] and *The Recruitment and Retention of Health Care Professionals*[10] have made similar observations about Northerners' more limited access to quality health services.

Thus, the issue of poor access to physician resources in northern, rural and underserviced areas is part of a larger concern of inequitable access to health care services. Nor is the problem of physician maldistribution unique to Ontario. It has been of long standing interest to consumers and providers of health care in all Canadian provinces and territories. Currently, federal, provincial, and territorial health ministers are working on the development of a *national* supply plan for physician resources.[11]

In some regions of Canada, efforts were tried unsuccessfully a few years ago to force doctors to practice in under-serviced areas. British Columbia attempted to grant billing numbers to new physicians only if they would go to rural areas. However, the B.C. Supreme Court ruled that such a policy was a violation of a person's right to practice his or her chosen profession where he or she wanted.[12]

This paper will examine the issue of access to physician resources in northern, rural and underserviced areas of Ontario. First it will look at the problems and concerns that discourage medical practitioners from practicing in these areas. Second, it will describe and evaluate several government and OMA-initiated programmes to improve the distribution and mix of physicians in rural and remote parts of Ontario.

The final section examines a controversial provision of the 1993 *Agreement* negotiated by the government and the province's physicians. In an effort to contain health care costs and to recruit physicians to underserviced parts of Ontario, the parties agreed to a temporary moratorium on issuing new billing numbers to physicians who have not been trained in the province. If an out-of-province physician wishes to re-locate and practice in Ontario, he or she must sign a service agreement to practice in an underserviced region and accept a contract or some form of alternate payment.

The paper begins, however, by examining the current distribution and mix of physicians in rural and underserviced parts of Ontario.

UNDERSERVICED AREAS

In 1990, the Canadian Medical Association (CMA) established an Advisory Panel on the Provision of Medical Services in Underserviced Regions. The Panel conducted a national survey of physicians in rural practice and released a report in 1992.

- In 1986 approximately 10% of physicians were practicing in rural Canada (defined as communities of less than 10,000)[13] whereas about 25% of Canadians were living in such areas.

- When the survey considered both small (under 10,000) and medium-sized (up to 100,000 population) communities, the urban/rural distribution of physicians was less marked. Approximately 40% of the population live in such areas. They are serviced by 35% of the general practitioners and approximately 20% of the specialists.[14]

- In addition, differences emerged between the numbers of Family Physicians/General Practitioners (FPs/GPs) practicing in rural areas compared with the numbers of specialists. FPs/GPs were distributed more evenly: in 1986 almost 20% of FPs/GPs were located in a rural area. Only about 5% of specialists were located in rural areas.[15] In rural areas, general surgeons are the

> predominant specialists, followed by general internists, a few radiologists, psychiatrists, and a scattering of others.[16]

The CMA Advisory Panel concluded that initial *recruitment* of general practitioners is not the primary concern. The main problem appears to relate more to difficulties in *retaining* physicians. For specialists, on the other hand, the problems may be *recruitment as well as retention.*[17]

Dr. James T.B. Rourke, a physician from Goderich, Ontario and past chair of the OMA Section on Rural Practice, provided a further analysis of the CMA data applicable to Ontario.

> 18.2 per cent of Ontario's population or almost 2 million people reside in rural communities of less than 10,000 population. 7.7 per cent of full-time Ontario physicians (12.8 per cent of full-time family physicians and three per cent of full-time specialists) practice in these areas . . . Most of rural Ontario as well as almost all of Northern Ontario was underserviced in terms of physician resources.[18]

In addition to the smaller physician to population ratio in rural areas, the physician workforce is aging. In 1992 the OMA Section on General Surgery surveyed its membership and found that the average age of the respondents was 52 years; 36.6% were over the age of 60; 25.3% were between the ages of 50 and 59; 20.8% were between the ages of 40 and 49; and 22% were under 40 years old.

Fewer and fewer young surgeons are inclined to go into general surgery, as the subspecialties have become a much more attractive alternative.[19] The CMA's Advisory Panel noted in its 1992 Report that "there is concern that potential shortages of specialists, particularly in specialties such as general surgery, will become even more acute in nonurban areas."[20]

Barriers/Problems Facing Medical Practitioners Who Practice In Underserviced Areas

Some of the factors that discourage physicians from practicing in rural or underserviced areas are generic to these types of communities. For example, it is difficult to motivate physicians to settle in areas that lack facilities, adequate medical technology and the infrastructure necessary to provide high-quality health care. Moreover, family physicians and

surgeons do not relish working long hours with little or no back-up services. In communities far from urban centres, physicians are vulnerable to feelings of professional isolation.

Preparation in Medical School

A concern that makes physicians wary of practice in rural and isolated settings is the lack of necessary clinical training. Dr. Keith MacLellan, former vice-president of the Society of Rural Physicians* is critical of family medicine programs. He argues that the thrust has moved away from teaching acute care skills and towards psychosocial skills (doctor/patient communication, counselling and interviewing skills, and identifying causes and emotional implications of disease). MacLellan further argues that although these are legitimate skills, when a patient comes into your office who has had a heart attack, a physician needs to be able to deal with its immediate complications. He believes that new graduates are unable to do that.[21]

Such training leaves the new family physicians ill equipped to handle the demands of rural practice, especially when they are unable to refer patients to specialists as their urban colleagues can. For example, some GPs are feeling less comfortable about delivering babies, or undertaking emergency or surgical procedures because of this lack of training.[22] Many rural doctors are refusing to handle births because they do not have the medical back up needed to deal with complications. Small town hospitals are facing severe shortages of general surgeons and anesthetists; specialists who can intervene if a woman needs an emergency caesarian section. Some rural GPs say it is just not worth the risk of malpractice suits, of losing a woman or her baby to handle even normal pregnancies when help may be more than an hour away.[23]

The 1991 Barer-Stoddart Report, *Toward Integrated Medical Resource Policies for Canada*, prepared by leading health care consultants for the federal/provincial/territorial conference of deputy ministers of health, saw the problem of medical school curricula as follows:

> Concerns were largely that the content did not reflect the changing health-care needs of the population, and that the training sites did not provide the range of exposures that would allow graduates to feel

* The Society of Rural Physicians (SRP) is a national group that is working to improve the working conditions of rural physicians.

> comfortable practicing outside urban areas and/or tertiary-care hospital environments.[24]

The Barer-Stoddart Report also criticized residency training and specialty certification, noting that "present clinical exposures and experience rarely provide levels of confidence and competence sufficient to encourage graduates to practice outside urban centres."[25]

Continuing Medical Education (CME)

Physicians in remote and underserviced areas also face difficulties in maintaining their knowledge and skills in all the varied aspects of their practice.[26] It is often difficult for rural physicians to secure uninterrupted free time for professional development. If they need replacements while they return to teaching hospitals in the urban areas to upgrade their medical education, they must compete for locum tenens with physicians in urban practices and walk-in clinics.[27] Finally, they must fund the considerable costs of CME, travel, tuition, accommodation and income replacement themselves.

Heavy Workload of Rural Family Physicians and Surgeons

A significant factor that causes physicians to `burn out' and leave rural practice is the long `on-call hours'. One rural physician described this pressure in the following fashion.

> For rural family physicians, being on-call often means providing hospital emergency, inpatient, obstetric and, sometimes, anesthesia services. A rural general surgeon often has no one to share on-call coverage with. These on-call demands often far exceed reasonable expectations in other areas of society.[28]

Some rural hospitals across Ontario are struggling to keep their emergency departments staffed at night. The problem is the fee-for-service system which pays doctors according to the number of patients they see. It works well during the day, but rural doctors can spend 12 hours in emergency at night and see only a handful of patients. Moreover, many are still expected to see their own patients the next day.[29]

According to a 1994 Ontario Hospital study, 54 of 169 hospitals surveyed were having difficulty operating their emergency departments, 46 were paying physicians extra to be on-call, 46 were under threat of having emergency services withdrawn, and 16 had reduced emergency services.[30]

Crisis in Rural Emergency Departments

There has been a growing crisis in emergency departments in small rural hospitals; some have closed their departments or cut back because they could not find the professionals to staff them.[31] In 1993, physicians in Goderich protested that they were subsidizing rural emergency rooms out of their own pockets and threatened to withdraw their services. The Ontario Hospital Association (OHA) responded by urging the College of Physicians and Surgeons to caution the Goderich doctors that they faced disciplinary action. The College refused. Instead, a tripartite committee was set up by the Ministry of Health, the OHA and the OMA to seek an independent fact-finder to report on the extent of the problem and to recommend solutions. The fact finder was to seek advice from all concerned stakeholders, including the sponsoring parties (MOH, OHA, OMA), physicians, hospitals and communities. Talks were also scheduled with the Canadian Medical Association and the Federal Department of Health and Welfare.[32]

In February 1994 the issue of on-call emergency medical coverage flared up in the northwestern Ontario community of Red Lake. Five doctors who provided primary care, full emergency coverage, general surgery, anesthesia, obstetrics, hospital and staff administrative services and committee work threatened to withdraw 24-hour on-call emergency room coverage of Margaret Cochenour Memorial Hospital. From April 1 to May 20, 1994, and from July 21 to November 30, 1994, the doctors provided limited or restricted on-call coverage, and the hospital resorted to a contingency plan. In the meantime, the Ministry of Health, the Red Lake doctors and the OMA commenced negotiations on March 16, 1994 and met about 20 times.[33]

Spousal and Family Considerations

Small or rural communities may provide few opportunities for employment or the career aspirations of a physician's spouse. Also, unmarried physicians may view a move to a small community as less promising in terms of meeting a potential mate. Where a physician and spouse have re-located to a small or rural community, they may find

their choices for children's schooling more limited than in an urban setting.[34]

RESPONSES TO THE PROBLEMS

Academic Health Science Centres and their Communities

The Provincial Coordinating Committee on Community and Academic Health Science Centre Relations (PCCCAR) was established in November 1993 to help academic health science centres (medical faculties) develop a better understanding of the communities they serve and to develop a closer and more cooperative working relationship with these communities. PCCCAR has various sub-committees and task groups that examine the issues of attracting health human resources to underserviced areas and keeping them there. Such groups include the sub-committee on Underserviced Area Needs, and the task group to examine human resource issues in emergency health services in small/rural communities.[35]

Fostering an Interest in the Study of Medicine Among Rural Students

Dr. James Rourke, a rural physician in Goderich, has suggested that attracting future medical practitioners might begin by fostering an interest in higher education (particularly the sciences) among rural students. Several medical associations and medical schools actively promote medicine in high schools as a possible career goal.[36] Moreover, research indicates that physicians who were raised in a rural setting are much more likely to return to a rural setting to practice medicine upon completing medical school. About half of all rural doctors working today come from small towns.[37]

A similar view appeared as a recommendation in the Barer-Stoddart Report:

> If geographic maldistribution (of medical practitioners) is a high priority problem, some entry class places should be reserved in medical schools for students from under-serviced areas. Alternatively, or perhaps in addition, some places should be reserved for applicants willing to sign (at time of admission) contracts for pre-or post-licensure

service provision in designated under-serviced areas.[38]

Attracting Health Care Students to Underserviced Areas

The Ministry of Health's Underserviced Area Program (UAP) was established in 1969 to encourage more health professionals to practice in remote areas of the province such as northern Ontario. It has since expanded its role to address the issue of health human resources in all areas of the province designated as underserviced. Bursaries and tax-free incentive grants have been provided to students and practitioners in medicine and dentistry under this program. Later, the program was expanded to include: physiotherapy, speech pathology, audiology, occupational therapy and chiropody.[39] The guidelines for the UAP and the specific programs it covers were revised in January 1995.

Bursaries

Early Ministry programs relied upon financial incentives such as bursaries to lure students to practice in the north. Students were required to commit themselves to `return of service' for each year of bursary assistance. The Ministry of Health now administers a bursary program that is wholly funded by the Ministry of Northern Development and Mines (MNDM). MNDM has provided funds for 120 bursaries for a number of health care disciplines through the Underserviced Area Program.

A $7,500 per year bursary is available to all Ontarians in their last two years of undergraduate study in the following disciplines: chiropody, medicine, occupational therapy, physiotherapy, and the last two years of a post-graduate program in audiology and speech language pathology. Bursaries are awarded to candidates who are willing to commit themselves to practicing in Northern Ontario. Recipients are obligated by the contract to return one year of service in Northern Ontario for each year of bursary assistance.[40] The program has had only modest success. Often the recipient of the bursary returns to an urban setting as soon as they have fulfilled their contract obligations.

2Ontario's Health Professionals Recruitment Tour

Held under the auspices of the Underserviced Area Program, the annual Health Professionals Recruitment Tour is now in its 16th year. It is a joint initiative funded by the Ministries of Northern

Development and Mines and Health. It is held each October in each of the five health science centres in Ontario (Ottawa, Kingston, London, Toronto and Hamilton). The tour assists designated communities to recruit health and social services personnel by providing an opportunity for them to meet with interested students and established professionals seeking positions in all disciplines, including several beyond the mandate of UAP.

In 1990, 500 students attended the tour -- a dramatic increase from the 220 students who attended in 1985. Essentially the recruitment tour is an opportunity for graduate students in health science centres to meet face to face with representatives from northern and rural communities.[41]

The 1994 Health Professionals Recruitment Tour took place October 17 - 21 with the two principal ministries hosting informative receptions in five cities. At each reception, hospital and clinic administrators, chiefs of staff, mayors and councillors were available to discuss life in their towns and communities and current opportunities for practice. Ministry representatives were also available to explain the details of possible financial incentives.[42]

Medical Education

The criticism that family medicine practitioners are ill-equipped to handle acute care patients is addressed by Paul Rainsberry, Director of Education for the College of Family Physicians in Canada. (This is the body that sets the curriculum for family medicine residency training programs). Rainsberry maintains that the program *can* produce a family physician who can handle just about anything that he or she might face. The problem, Rainsberry argues, is that two years is insufficient to prepare doctors for the special skills needed in rural communities. He adds that it is unrealistic to expect graduates of any training program to function immediately like an experienced doctor who has honed his or her skills through years on the job.[43]

In Ontario, the Deputy Minister's Advisory Committee on Family Medicine Training and Licensure recommended in 1988 that government accept a two year pre-licensure clinical training requirement.[44] It further recommended that training sites should be established in Northern Ontario first. Effective July 1, 1993, the College of Physicians and Surgeons of Ontario announced that two years of pre-licensure clinical training would be required for medical practice. The Ministry supported the move to a two-year training

requirement and family medicine as the preferred route into non-specialty practice. On May 22, 1990, then Premier David Peterson announced the expansion of southern family medicine programs and the development of the Northern Family Medicine Residency Training Program (NFMRTP) to be administered through the health science education resource centres in Sudbury and Thunder Bay.

A factor that may foster a willingness to practice in rural areas is exposure to rural practice during undergraduate medical education. Most medical schools now provide this opportunity.[45] Postgraduate training may also provide important exposure to the joys and challenges of rural practice, according to Dr. James Rourke, past chair of the OMA Section on rural practice.

> Considerable progress has been made in this area, at least for family practice, through the cooperation of medical schools and ministries of health. More attention needs to be paid to these factors in postgraduate training, particularly for residents in psychiatry, general surgery and internal medicine. As well, rural communities that have medical students or residents are more likely to be able to attract their needed complement of physicians.[46]

This view was echoed by the CMA's 1992 *Report of the Advisory Panel on the Provision of Medical Services in Underserviced Regions*.

> All Canadian medical schools have provision in their undergraduate programs for exposure to rural practice, and, in some medical schools, this experience is mandatory. Although all medical schools have provision for rural experience for family medicine residency training programs, there is much less exposure to rural practice during postgraduate training for other specialty disciplines; the panel believes this should change.[47]

Ontario's Northern Family Medicine Residency Training Program (NFMRTP)

The Northwestern and Northeastern Ontario Family Medicine Programs, which together form the NFMRTP, are two northern residency programs that offer a unique approach to training. Their goal is to encourage physicians to train and later practice medicine in the

north. It was reasoned that providing training in a northern setting would be more effective than offering doctors money to lure them to the north after they are already trained and practicing in southern Ontario. As one critic pointed out, "giving doctors financial incentives only keeps them for as long as those incentives are in place."[48]

The objective of the Northern Family Medicine Residency Training Program is to provide a decentralized, accredited, family medicine experience to trainees for the purpose of enhancing recruitment and retention of physicians in Northern, rural and remote areas of the province and in francophone, native, and multi-cultural communities.[49]

The Ontario Ministry of Health appointed an Implementation Advisory Group to develop the NFMRTP, announced in 1990.[50] Advisory Group membership included the Council of Ontario Faculties of Medicine (COFM), Lakehead, Laurentian, McMaster and Ottawa universities, and physicians involved in the Northwestern and Northeastern Family Residency Programs. The northwestern program is affiliated with McMaster University medical school while the northeastern program is affiliated with the University of Ottawa medical school. Both operate within independent infrastructures in Thunder Bay and Sudbury, respectively.

In 1990 Management Board approved a grant by the Northern Ontario Heritage Fund Corporation to construct the necessary infrastructure for the NFMRTP and other health sciences education and clinical training in Northern Ontario. The $9 million grant was equally divided to cover the construction, equipment and furnishings for two Health Science Education Resource Centres. The Thunder Bay project was managed by Lakehead University and the Sudbury installation was managed by Laurentian University.[51]

The Health Science Education Resource Centre (HSERC) on the Lakehead University campus opened officially in September 1991 at a cost of $4 million. Lakehead used the $500,000 surplus from the project to begin additional construction of a 96-bed residence, of which 24 beds were to be reserved for the exclusive use of medical trainees and trainers participating in the HSERC program. The Sudbury HSERC opened at Laurentian University in October 1993.[52]

The NFMRTP provides opportunities for residents to obtain certification in Family Medicine with comprehensive experience in northern and rural environments over the entire training period of two to three years.

1993/94 funding for the NFMRTP was $3,914,263 which includes geographic full-time (GFT) professor fees, administrative costs, travel expenses, and the salaries and benefits of 52 trainees. Development funds of $1.5 million were awarded to the medical schools (through the Council of Faculties of Medicine) in 1990/91. These start-up funds were distributed to the five faculties of medicine and the two northern sites for recruitment, communications, computers, faculty development and other start up costs. The following tables summarize the funding for the family medicine expansion and decentralization program from 1990/91 to 1993/94. Funding for 1994/95 will remain at the previous year's level.

Summary Of Family Medicine Expansion And Decentralization Program: 1990/91 To 1993/94

	90/91 Dev Funding	91/92 Funded (9 mo)	92/93 Funded (12 mo)	93/94 Funded (12 mo)
# of New Residency Positions	0	0	78	84
Operating costs				
Northern Program				
Thunder Bay	411,000	904,375	1,311,193	1,368,021
Sudbury	434,000	500,818	863,800	1,197,127
Northern Total	**$ 845,000**	**$1,405,193**	**$2,174,993**	**$2,565,148**
Southern Program				
McMaster	33,750	72,750	149,835	166,500
Ottawa	111,200	328,750	569,940	599,830
Queen's	100,500	261,450	420,375	427,750
Toronto	302,000	582,000	1,243,000	1,305,314
Western	178,624	242,500	560,500	560,500
Southern Total	**$726,074**	**$1,487,450**	**$2,943,650**	**$3,059,894**
Total Northern + Southern	**$1,571,074**	**$2,892,643**	**$5,118,643**	**$5,625,042**
Salaries/benefits Of New Trainees	0	0	2,975,095	4,168,925
Grand Total	**$1,571,074**	**$2,892,643**	**$8,093,738**	**$9,793,967**

Source: Ontario Ministry of Health, Health Human Resources Policy Branch (30 November 1994).

Summary Of Family Medicine Expansion And Decentralization Program: 1990/91 To 1993/94

North/south Cost Breakdown By Category				
	90/91 Dev Funding	91/92 Funded (09 Mo)	92/93 Funded (12 Mo)	93/94 Funded (12 Mo)
Northern Program				
# Of Trainees	0	22	46	52
Start-up Costs	845,000	--	--	--
Gft Fm Profs*	--	206,250	493,750	293,500
Operating Costs	--	1,198,943	1,681,243	2,271,648
New Trainee Salary/benefits	--	0	863,437	1,349,115
Total	**$845,000**	**$1,405,193**	**$3,038,430**	**$3,914,263**
Southern Program				
# Of Trainees	365	420	460	460
Start Up Costs	726,074	--	--	--
Gft Fm Profs*	--	525,000	1,225,000	1,385,534
Operating Costs	--	962,450	1,718,650	1,674,360
New Trainee Salary/benefits	--	0	2,111,658	2,819,809
Total	**$726,074**	**$1,487,450**	**$5,055,308**	**$5,879,703**
Grand Total	**$1,571,074**	**$2,892,643**	**$8,093,738**	**$9,793,966**

Source: Ontario Ministry of Health, Health Human Resources Policy Branch, (30 November 1994).

* (clinical teachers in the field are known as geographic full-time family medicine professors).

Impact of the Residency Program

A graduate of McMaster Medical School in Hamilton and a resident-in-training with the Northeastern Ontario Family Medicine Residency Program in 1992 was interviewed by the *Sudbury Star* about his training experience in the Manitoulin Island community of Gore Bay:

> You're given a lot more responsibility and you gain more experience by learning in hospitals and

> community settings . . . You have to learn more quickly and you have to learn more in general. Most residents are anxious to get what you might call a real world training and that is what this is.[53]

It is believed that these doctors will have exceptional insight into the difficulties and challenges of practice in northern Ontario and could act as influential mentors to trainees considering a career in the North.[54]

Of the 27 graduates of the family medicine residency training in Thunder Bay's Northwestern Ontario Family Medicine Program, 14 are currently practicing in the north (5 Thunder Bay, 2 Sault Ste Marie, 2 Sioux Lookout, 1 Atikokan, 1 Emo, 1 Espanola, 1 Kapuskasing, 1 Kenora). Five are taking additional training, three are practicing in southern Ontario, three have left the province. The location of two Thunder Bay program graduates is unknown.[55]

Of the 23 graduates of the Sudbury program, 12 are now practicing in northern Ontario (4 Sudbury, 3 Timmins, 1 North Bay, 4 are northern locums), three are pursuing additional training, three have left the province, four are practicing in southern Ontario. The location of one Sudbury program graduate is unknown.[56]

Removing Barriers to Continuing Medical Education

As part of the August 1st 1993 *Agreement* negotiated between the Ontario Ministry of Health and the OMA, the parties reached a consensus on the issue of supply and distribution of physicians practicing in Ontario.[57] They also agreed on the following goals: a) to increase physician numbers in underserviced areas; and b) to retain physicians in areas in which recruitment is difficult.[58]

Key among the distribution measures negotiated between physicians and the government was an item on continuing medical education, an ongoing concern for many rural physicians. Under the *Agreement*, (which expires on March 31, 1996) Continuing Medical Education will be handled as follows:[59]

2.1 The Government will provide $3 million per year to the OMA annually to fund and administer a Continuing Medical Education (CME) program for physicians who have been practicing in specified communities (hereinafter "specified" communities means communities having a population of less than 10,000 and

located more than 80 km from a major referral centre whose population exceeds 50,000).

2.2 The fund would provide assistance for CME registration; travel, accommodation and associated expenses; and income replacement associated with CME leaves.

2.3 The OMA will make public the terms and conditions of the program, publish an annual report and be open to audit by the Provincial Auditor.

2.4 The fund will be transferred to the OMA within sixty days of ratification of this agreement by the parties.

The program is overseen by the OMA's CME Governance Committee. Its membership includes physician representatives from the target communities, a representative from each of the Ontario College of Family Physicians and the chairs of family medicine, and associate deans of CME from Ontario medical schools.[60]

A necessary component of the CME program for physicians is an effective locum tenens program. The 1993 *Agreement* included the following:[61]

3.1 The Government and the OMA will, within 60 days, meet and review existing locum tenens programs with a view to co-ordinating or combining locum tenens programs.

3.2 As a minimum and pending the above, the Government will provide the OMA with $1.5 million annually to administer a locum tenens program to assist physicians practicing in specified communities by covering their practice responsibilities while away on vacation and other short leaves.

3.3 The program will include payment to locum physicians for services rendered when working, on call or on standby, and reimbursement for associated travel and other expenses.

3.4 The OMA will make public the terms and conditions of the program, report periodically on the activities and achievements of the program, publish an annual report and be open to audit by the Provincial Auditor.

3.5 The fund (under 3.2 above) will be transferred to the OMA within 60 days of ratification of this agreement.

It is believed that the development of a separate, rural-targeted, funded and committed locum service should help provide more isolated rural physicians with practice coverage for leaves. However, a past chair on rural practice commented that this program will only be successful if physicians practicing in rural, northern and underserviced areas are involved in its development and decision-making.[62]

The OMA Locum Tenens Program

The OMA Locum program established in 1993, is now fully operational and is successfully providing locums to geographically designated communities to assist physicians to obtain leave for CME or vacation. The OMA has established a central registry of locums for approximately 80 designated communities in northern and southwestern Ontario. The OMA locum program draws upon a pool of well-trained professionals who must pass an accreditation course. If they pass, they are interviewed by 3 physicians from northern/underserviced areas.[63]

The `fly-in' locums sign a one-year contract with the OMA. They receive a retainer of $1,000 per month and guaranteed $500 per day in fees while practicing. The OMA will reimburse the cost of their administrative expenses (accommodation, travel expenses and one trip home a month).[64] The minimum length of stay of the fly-in physician is 5 days and the maximum is 28 days. The OMA has received positive feedback from medical practitioners who have used the service. The program will produce an evaluation and an annual report. In exchange for accepting $1.5 million (per annum) to start up this program, the OMA has agreed to limit its intake of locums to those who graduate from Ontario medical schools.[65] The OMA locum program is quite separate and distinct from the UAP program (see below).

UAP's "Urgent" and "Respite" Locum Tenens Programs

The Ministry of Health's Underserviced Area Program assists communities experiencing an acute shortage of physician services due to illness, death or difficulty in recruiting full-time physicians, by providing temporary medical services through the "urgent locum program" or the "respite locum program". The urgent locum program provides medical services for specified periods in approved northern Ontario communities where recruitment of a full-time physician has been a chronic problem, mainly due to low population base or geographic isolation.[66] The respite locum program provides temporary

relief for established general/family physicians working in designated underserviced areas of northern Ontario.[67] The remuneration for the locums varies, depending on the program. The locum physician may claim either a stipend from the UAP or bill fee-for-service from OHIP, but cannot alternate between the two methods of payment.[68]

Improving Incentives for Physicians To Practice in Designated Areas in Northern Ontario

The UAP program also provides incentive grants to physicians in return for establishing their practice in a designated underserviced area. The Incentive Grant Program offers tax free grants of up to $40,000 paid over a four year period to physicians who have relocated to a designated underserviced area.

> For designated areas in northern Ontario, general/family physicians and psychiatrists are eligible to apply for an income tax-free incentive grant of up to $40,000 paid quarterly.
>
> For designated areas in northern Ontario, specialists, excluding psychiatrists, are eligible to apply for an income tax-free incentive grant of up to $20,000 paid quarterly.
>
> If a specialist is willing to provide a minimum of 12 days of outreach services per year to communities at least 40 km from one's home base, one is eligible to apply for an additional income tax-free incentive grant of up to $20,000 paid quarterly. This additional grant must be applied for within four years of establishing a practice in an underserviced area.[69]

The incentive grant program also applies to general/family physicians in designated areas in Southern Ontario.

Within the Ministry-OMA Agreement, an incentive also exists for medical specialists who practice in underserviced areas. Specialists who are deemed to be working in an underserviced area are entitled to earn *above* the threshold payment amount.[70]

Staffing Rural Hospital Emergency Departments: Resolving the Crisis

Three years ago, four physicians from Mount Forest (60 miles north of Kitchener-Waterloo) won a landmark deal from the provincial government concerning hospital emergency services. The result was a government-funded package paying the Mount Forest doctors an hourly on-call wage, making it feasible for them to close their office practices the day after attending a night of emergencies. Dr. Ken Babey, one of the Mount Forest Physicians and secretary of the Society for Rural Physicians expressed the hope that this problem could be addressed on a national level. According to Babey,

> Unless the federal government takes an interest and helps to coordinate some of this impetus, we are going to have to solve these problems piecemeal, province by province.[71]

In response to Goderich physicians objecting to the conditions under which they provided emergency care, an OMA, OHA and MOH task force recently tackled the issue of rural family physicians putting in long `on call' hours. The task force published guidelines to set reasonable on-call limits and adopted strategies to address the demand for services.[72] The parties could not, however, agree on how to pay the physicians or where to get the funds.[73] The past chair of the OMA Section on Rural Practice has argued in favour of funding alternatives for small volume emergency departments in rural areas to address problems such as difficult cases with little professional back up, sleep deprivation, and long hours of `on-call' service.[74]

It was reported in October 1994 that, at the request of the Ministry of Health, the Provincial Co-ordinating Committee on Community and Academic Health Science Centre Relations (PCCCAR) established a short-term subcommittee,** chaired by Dr. James Rourke to examine human resource issues in emergency health services in small/rural communities, particularly:[75]

- training, education and continuing education of providers;
- ongoing practice support for providers;

** The task group will include representatives from a rural district health council, a rural hospital administrator, nurses who provide emergency health services, physicians who provide emergency health services, the five academic health sciences centres, the Provincial Emergency Review, PCCCAR and the Ministry of Health.

- regional networks for provider supply; and
- the role of academic health science centres.

On December 14, 1994, Minister of Health Ruth Grier announced that the five Red Lake doctors and the OMA had ratified an agreement to restore on-call emergency medical coverage in that northwestern Ontario community. Under the four-year agreement, the doctors will have their 1993/94 fee-for-service earnings converted into a global fund. A steadier income will allow individual doctors to arrange more flexible office hours and maintain emergency coverage at the hospital. A sixth doctor will be recruited and funded by the ministry based on the average billings of the five Red Lake doctors. The funding for a sixth doctor became available when nearby Ear Falls agreed to give Red Lake one of its two designated doctors for the duration of the agreement. Until the sixth doctor is recruited, the ministry's Underserviced Area Program (UAP) will fund a respite locum in Red Lake.[76]

Independent Assessment by Fact Finder Graham Scott, Q.C.

In late 1994, the Ministry of Health, Ontario Medical Association and Ontario Hospital Association, jointly asked Graham W.S. Scott to conduct an independent assessment of the situation concerning on-call emergency services in small rural hospitals. On March 22, 1995, Mr. Scott released *Report of the Fact Finder on the Issue of Small/Rural Hospital Emergency Department Physician Service*. The Report contained 22 findings and 30 recommendations. The recommendations addressed physician incomes, medical education, hospitals, communities and short-term changes. The following recommendations pertained to rural physician incomes.

- Rural physicians must be competitively paid;
- A globally-funded group practice is a desirable model for rural areas;
- The OMA/MOH should establish a globally funded group practice pilot project in northeastern or northwestern Ontario;
- A Direct Contract Program (DCP) should replace fee-for-service (FFS) as the preferred funding mechanism in rural northeastern or northwestern Ontario;

- Establish DCP as the preferred method of physician remuneration in rural areas;
- Give rural FFS physicians priority to convert to DCP or globally-funded group practice provided they meet the requirements;
- Allow qualified, rural physicians that remain on FFS to claim a $70.00 hourly rate for the 12 hour overnight on-call duty in the ER and for each hour of on-call duty on the weekend from Friday evening to Monday morning and on official holidays.
- Require FFS physicians to close their practices until 2:00 p.m. the day following their overnight ER service;
- Augment by 5% the incomes of qualified FFS physicians who serve a full on-call rotation, whereas FFS who withdraw from on-call would lose the 5% augmentation.[77]

The Ministry of Health has asked for a meeting with the OMA and OHA to discuss the recommendations of the Scott Report.

Prohibiting Out-Of-Province Medical School Graduates From Fee-for-Service Billing

The 1991 Barer-Stoddart Report discouraged the practice of favouring home province applicants to medical schools. Rather, the Report recommended that medical schools throughout Canada should be accessible to qualified applicants of any province.

> `Home-province' advantage for applicants should be eliminated or reduced, so that medical schools become a `national resource' equally available to all Canadian students irrespective of their province of residence.[78]

In their 1993 *Agreement*, however, the Ontario government and the Ontario Medical Association sought to regulate the growth in the number of physicians practicing in Ontario, while ensuring that graduates of Ontario medical schools are given an opportunity to practice. The government decided that as an interim measure it would regulate the number of physicians entering the province by instituting a temporary moratorium on issuing new billing numbers to physicians who had not trained in the province.[79] According to the *1993 Agreement Between the Ministry of Health and the OMA*,[80] doctors

entering Ontario with degrees from medical schools outside the province will be able to practice medicine only if they go on salary or accept some other form of alternate payment. They will not be allowed to bill OHIP under the fee-for-service system.

This measure was designed in an effort to cut costs under the province's Social Contract and second, to encourage new doctors to practice in underserviced areas in the province.[81] Commenting on the measure in August 1993, Health Minister, Ruth Grier said: "the proposed new deal commits the OMA to work with the government to recruit doctors to Northern Ontario."[82] The provincial government and the OMA hope to recruit approximately 100 doctors to work in Northern Ontario under the new deal. Soon after the *Agreement* was ratified, the government and the OMA were to determine which communities should be designated "underserviced" areas and provided with two physicians.[83] The moratorium will last until March 31, 1996, when the rest of the province's Social Contract program expires.

Effect Of Public Policy

On December 5, 1991, (then) Deputy Minister of Health Michael Decter delivered a speech to the Sudbury District Medical Society. He discussed the concern that the special needs of the north were being ignored. He noted the positive rate of growth in the number of GPs and specialists in the north and he argued that this could be attributed to the special recruitment, funding and support for short-term replacement physicians.

> The Underserviced Area Program has an excellent track record in providing a four-year incentive for general practitioners and specialists to relocate to the north.
>
> Currently, the rate of growth in the number of general practitioners in the north exceeds the average growth for the entire province. Between 1981 and 1989 the number of non-specialists in the north increased by 33 percent. Compare that to a 28 percent rate of growth in the south.
>
> The rate of growth for specialists is not as spectacular, but is still significant. In the same

> period, specialists in the north grew in number by 28 percent compared to a southern figure of 37 percent.
>
> This growth is being maintained through special funding for recruitment, incentives for developing off-site clinics, and support for providing short-term replacement physicians. [Locum Tenens]
>
> In addition, local communities receive special assistance to help fill their individual needs. Local institutions, using fully developed guidelines can request funding for the specialists they need to improve the quality and access to care in their areas.
>
> As a result of this program and others, the ratio of active general and family practitioners in the northeast improved from 62 per 100 thousand people in 1981 to 83 per 100 thousand in just eight years. The ratio for specialists in the region jumped from 43 per 100 thousand to 56 per 100 thousand in the same period.
>
> Particularly relevant to the current discussion is the clear statement, in the Economic Agreement, that GPs and specialists working under the Underserviced Area Program are automatically exempt from the Threshold Payment Adjustment provision.[84]

A major consultant's report had been less optimistic. In the early 1990s, the Ontario Ministries of Northern Development and Mines, Health, and Community and Social Services contracted management consultants Peat Marwick Stevenson & Kellogg to undertake a comprehensive study of the issues of shortages and rapid turnover of health and social service professionals in Northern Ontario. Despite the presence of financial, educational and other initiatives that have been put in place by government, shortages and turnover among these professionals continued.[85] One of five objectives of the study was "to evaluate the Northern recruitment, incentive and bursary programs and to recommend how such programs can be strengthened."[86]

Among the report's recommendations were items which addressed spousal considerations and the Health Professionals Recruitment Tour which have already been discussed. The report argued that recruitment and retention strategies should include due consideration for the

professional and his or her spouse. It also recommended that the rationale and objectives of the Recruitment Tour be clearly articulated, and that its objectives be stated in measurable terms.[87]

In terms of the bursary programs, the consultant's report recommended that the province improve its communications strategy to inform agencies and communities about the programs and involve them in the selection of bursary students. It was further suggested that the government establish a central clearing authority through which all bursary students could circulate their resumés to northern agencies and facilities. It called for enhanced interministerial cooperation and a review of funding levels in order to determine the amount and distribution strategy which would achieve the recruitment and retention objectives of the bursary. The province was also urged to develop clear objectives for the bursary program including regular, more efficient program monitoring, use of information systems, and periodic evaluation studies.[88]

The UAP's Incentive Grants Program was also put under the microscope and it too was urged to develop clearly articulated objectives and measurable targets. It was suggested that funding levels for the Incentive Grants Program be periodically reviewed to reflect changing economic and social conditions with a view to differentially compensating professionals according to specific characteristics of underserviced areas. It was suggested that the UAP review eligibility criteria to eliminate duplication (e.g. where a bursary recipient who is fulfilling a return-of-service commitment gets an incentive grant at the same time). The importance of regularly monitoring the effectiveness of the Incentive Grants program was highlighted in the study. It also urged that the UAP program improve its monitoring and data collection procedures for all its programs.[89]

The Peat Marwick Stevenson & Kellogg study was thorough and served as one of the first `call to action' reports to advocate a broad provincial policy framework for health and social services human resources planning. But it also focussed its attention upon improving the incentive-based bursary and grant programs. By the time the report was released in 1992, however, it had been overshadowed by other events.[90] The dialogue had begun to shift away from incentive-based programs and towards non-financial incentives such as continuing medical education, an effective locum tenens program, northern residency programs, and spousal considerations. At approximately the same time, the Barer-Stoddart report, *Toward Integrated Medical Resource Policies For Canada* was published. This aptly-named report argued that to address the issues of an imbalance of physician

resources, one had to accept that many of the problems were `interdependent', and should not be addressed in isolation.

> What struck us during the life of this project was not just the complexity of each issue area taken separately, but the fact that so many issues were so very interdependent. It is this `inter-complexity' – the fact that, to have any chance of meeting their objectives, initiatives in one area must be accompanied by concurrent policies in another – and the diversity of regional and provincial problems, which present the greatest challenges to a `national approach' to policy co-ordination in this critically important area of health policy.[91]

Conclusion

Many organizations, institutional and professional associations, academic health science centres and governments at the provincial and national level have worked to understand and address the long-standing problems associated with an imbalance of physician resources within northern and remote regions in Canada. Groups such as the Canadian Medical Association and its subcommittees, the Society of Rural Physicians, the Ontario Medical Association and its various committees, and the federal/provincial/territorial health ministers (working singly and collectively) have tried to bring the problems of physician supply and demand into balance. Currently, federal/provincial/territorial health ministers are working on the development of a national supply plan for physician resources.[92]

This paper has illustrated how the imbalance of physician demand and supply has evolved in Ontario and how government and the medical community have responded. The paper has looked at some of the concerns faced by physicians contemplating medical practice in remote and underserviced areas of the province. It has examined the joint efforts of government, physician associations and others to reduce and alleviate those concerns. Finally, it has considered the many and varied policies that have evolved to recruit and retain physicians to underserviced areas of Ontario.

NOTES

[1] According to the *Thunder Bay Chronicle Journal*, on April 6, 1994, the Member from Kenora (Frank Miclash) was ejected from the Legislature during a heated debate over emergency services at Margaret Cochenour Memorial Hospital in Red Lake. The Member was removed for making unparliamentary remarks about Ontario's Health Minister, Ruth Grier. The *Thunder Bay Chronicle Journal* explained that: "The hospital's five doctors withdrew after-hours emergency services late last week, saying they should be paid more. A temporary government-appointed doctor could only stay until Monday and the hospital now has no after hours emergency services." The Member feared that deaths could occur if alternate emergency service could not be provided. The doctors withdrew their services in a protest over emergency-service compensation. Late-night emergency services are paid for on a per patient basis only. A doctor who performs after hours emergency duty is poorly paid if there are few patients. The problem is not unique to northern Ontario, but is exacerbated in remote communities because there are fewer doctors to perform the on-call service. Doctors who provide on-call service must also be available to see their regular patients during the day. According to the hospital doctors, rural doctors who balance regular practices with late-night on-call services must keep irregular hours and, therefore, should be better compensated." Source: Rob Savage, "Angry words get MPP booted from legislature," *T.B. Chronicle Journal*, 7 April 1994, p. A4.

[2] On May 31, 1994, Liberal Leader, Lyn McLeod asked a question of the Minister of Health (Ruth Grier). She raised the issue of emergency care in small, rural and northern Ontario hospitals. According to Mrs. McLeod, these hospitals are `topping up' doctors' salaries out of the hospital's global budget in an effort to keep their emergency wards open. Source: Ontario, Legislative Assembly, *Hansard: Official Report of Debates*, 35th Parliament, 3rd Session (31 May 1994): 6518 - 6520.

[3] On July 13, 1993, MPP David Ramsay (Timiskaming) made a statement in the Legislature during Member's Statements. He noted that he had travelled northeastern Ontario the previous week. He expressed concern that there is a growing health care crisis in the north due to the shortage of specialists. Sudbury, he noted, had a severe shortage of orthopaedic surgeons. Timiskaming is short of anaesthetists resulting in the postponement of elective surgery. Englehard will only have one doctor by August. Source: Ontario, Legislative Assembly, *Hansard: Official Report of Debates*, 35th Parliament, 3rd Session (13 July 1993): 2397 - 2398.

[4] On May 18, 1994, MPP, Sean Conway (Renfrew North) asked a question of the Minister of Health with respect to the problems that small rural hospitals are having, to attract and retain physicians to support a whole range of their services, including emergency services. Source: Ontario, Legislative Assembly, *Hansard: Official Report of Debates*, 35th Parliament, 3rd Session (18 May 1994): 6393 - 6394.

[5] Sharon Kirkey, "Rural doctors going on the endangered list," *Toronto Star*, 17 July 1994, p. F4.

[6] Ontario, Panel on Health Goals for Ontario (Robert A. Spasoff, Chair), *Health For All Ontario: Report of the Panel on Health Goals for Ontario* (Toronto: The Panel, 1987), p. 87.

[7] Ibid.

[8] "Northerners get poorer health care at higher costs than people in the south. In particular, many health services are not available and most people cannot afford the expense of travelling to them." Source: New Democratic Task Force of Ontario, Task Force on Northern Health Issues, *Operation Critical: The Report of the New Democrat Task Force on Northern Health Care Issues* (Toronto: The New Democratic Party, 1990), p. 1.

[9] "Ontario's immense geography leads to special health-care delivery problems. The 1987 Evans and Spasoff Committees emphasized the need for equity and equality of access to health care. Fiscal, geographic and demographic factors in Ontario make those objectives difficult to achieve. The same degree of access to care is not possible for all regions of Ontario." Source: Ontario Medical Association, Special Committee on Northern Affairs, *Report on the Northern Health Travel Grant Program* (Toronto: The Committee, 1988), p. 2.

[10] "Eighty-five per cent of the land mass of Ontario supports less than ten percent of the people. That fact, more than any other, affects the quality of life of people who live in the North. The health care system in Northern Ontario has problems that are a direct result of geography and demography. Its citizens have the same health-care needs as those in the more populous south; however, the methods of providing access to that care must necessarily be different." Source: Ontario Medical Association, Special Committee on Northern Affairs, *Northern Health Care: The Recruitment and Retention of Health Care Professionals* (Toronto: The Committee, 1988), p. 1.

[11] *The Globe and Mail* reported on September 16, 1994 that at a meeting of provincial and territorial health ministers in Halifax, a proposal was discussed about creating a national supply plan for physician resources. Such a national plan would be developed in cooperation with provincial medical associations. The proposal sparked an initial negative response from an Ontario Medical Association spokeswoman. She said that "her organization opposes such coercive measures for ensuring medical services in undersupplied areas." Reg Perkin, the executive director of the College of Family Physicians agreed. He said "his organization is also strongly opposed to any coercive measures. He said it would be easier to persuade his members to work in remote areas if governments would fund more years of training so family physicians felt more secure doing work such as anesthesia and complicated obstetrics farther away from hospital backup." Source: Jane Coutts, "Plan proposed to limit new MDs," *Globe and Mail*, 16 September 1994, p. 1.

[12] Sharon Kirkey, "Rural doctors going on the endangered list," *Toronto Star*, 17 July 1994, p. F4.

[13] Canadian Medical Association, Advisory Panel on the Provision of Medical Services in Underserviced Regions, *Report of the Advisory Panel on the Provision of Medical Services in Underserviced Regions* (Ottawa: Canadian Medical Association, 1992), pp. i-ii.

[14] Ibid.

[15] Ibid.

[16] James T.B. Rourke, MD, CCFP (EM), FCFP, "Politics of rural health care: recruitment and retention of physicians," *Canadian Medical Association Journal* 148:8 (15 April 1993): 1281.

[17] Canadian Medical Association, *Report of the Advisory Panel* p. ii.

[18] James T. B. Rourke, MD, CCFP (EM), FCFP, "The Politics of rural medical care: forces for change," *Ontario Medical Review* (August 1994): 17-18.

[19] Ciaran Kealy, MD, FRCSC, "General surgery not dead -- at least, not yet," *Ontario Medicine* (August 1994), p. 13.

[20] Canadian Medical Association, *Report of the Advisory Panel* p. ii.

[21] Sharon Kirkey, "Rural doctors going on the endangered list," *Toronto Star*, 17 July 1994, p. F4.

[22] Michael Oreilly, "Bitter physicians react angrily to uncertain future facing rural medicine," *Canadian Medical Association Journal* (15 February 1994): 572.

[23] Sharon Kirkey, "Rural doctors going on the endangered list," *Toronto Star*, 17 July 1994, p. F4.

[24] Federal/Provincial/Territorial Conference of Deputy Ministers of Health, *Toward Integrated Medical Resource Policies for Canada*, Morris L. Barer, Greg L. Stoddart (Canada: s.n., 1991), p. 9.

[25] Ibid., p. 11.

[26] Rourke, "Politics of rural health care: recruitment and retention of physicians," p. 1282

[27] Rourke "The politics of rural medical care: forces for change," p. 20.

[28] Rourke, "Politics of rural health care: recruitment and retention of physicians," p. 1282.

[29] Sharon Kirkey, "Rural doctors going on the endangered list," *Toronto Star*, 17 July 1994, p. F4.

[30] Ontario, Ministry of Health, "Emergency Room doctors. . .meeting the needs of rural and small hospitals," *Final Submission to Fact Finder Graham Scott,* (Toronto: The Ministry, February 1995), p. 1.

[31] Ontario, Provincial Coordinating Committee on Community and Academic Health Science Centre Relations (PCCCAR), "Health Human Resources and Emergency Health in Small/Rural Communities" *Newsletter* (PCCCAR Report No. 2 - October 1994), p. 2.

[32] Colin Muncie, "Rural docs go national," *Ontario Medicine* (October 1995), p. 5.

[33] Ontario, Ministry of Health, "Red Lake doctors agree to restore emergency medical coverage," *News Release*, 14 December 1994, pp. 1-2.

[34] Rourke, "Politics of rural health care: recruitment and retention of physicians," p. 1282.

[35] Ontario, Provincial Coordinating Committee on Community and Academic Health Science Centre Relations (PCCCAR) *Newsletter* (PCCCAR Report No. 2 - October 1994), pp. 1-4.

[36] Rourke, "Politics of rural health care: recruitment and retention of physicians," p. 1282.

[37] Sharon Kirkey, "Rural doctors going on endangered list," *Toronto Star*, 17 July 1994, p. F4.

[38] *Toward Integrated Medical Resource Policies for Canada*, p. 9.

[39] Information sent by David Salter, Program Manager, Northern Health Programs and Planning Branch, Ministry of Health on January 30 1995. *Underserviced Area Program*, "Summary of Components" pp. 1-2.

[40] Ibid., `Return of service' starts within six months following completion of training which may include internship, residency or clinical placement, depending on the profession. The area of the province in which return of service is acceptable includes the Districts of Algoma, Cochrane, Kenora, Manitoulin, Nipissing, Parry Sound, Rainy River, Sudbury Timiskaming and Thunder Bay.

[41] Garry Marr, "Tour promotes underserviced areas to doctors," *Medical Post,* 22 September 1992, p. 5.

[42] Ontario, Ministry of Health, Underserviced Area Program, "1994 Health Professionals Recruitment Tour," *Notice* (Sudbury: Northern Health Programs and Planning Branch, 3 October 1994), p. 1.

[43] Sharon Kirkey, "Rural doctors going on the endangered list," *Toronto Star*, 17 July 1994, p. F4.

[44] The information on the Northern Family Medicine Residency Training Program (NFMRTP) was kindly provided by the Ontario Ministry of Health's Health Human Resources Policy on November 30, 1994, via the Communications and Information Branch on December 16, 1994, p. 1.

[45] Rourke, "Politics of rural health care: recruitment and retention of physicians," p. 1282.

[46] Ibid.

[47] Canadian Medical Association, *Report of the Advisory Panel*, pp. i-ii.

[48] Denis St. Pierre, "Northern Exposure: A program has been set up in hopes of establishing a long line of physicians who will train and later set up shop in the North," *Sudbury Star*, 31 March 1992.

[49] This information on the Northern Family Medicine Residency Training Program (NFMRTP) was kindly provided by the Ontario Ministry of Health's, Health Human Resources Policy Branch on November 30, 1994, via the Communications and Information Branch on 16 December 1994, p. 1.

[50] Ibid., p. 2.

[51] Ibid.

[52] Ibid.

[53] Denis St. Pierre, "Northern Exposure: A program has been set up in hopes of establishing a long line of physicians who will train and later set up shop in the North," *Sudbury Star*, 31 March 1992.

[54] Kathryn Harvey, "Physician Resources Issues in Northern Ontario," *Ontario Medical Review* (May 1993): 33-35.

[55] This information on the Northern Family Medicine Residency Training Program (NFMRTP) was kindly provided by the Ontario Ministry of Health's, Health Human Resources Policy Branch on November 30, 1994, via the Communications and Information Branch on 16 December 1994, p. 3.

[56] Ibid.

[57] The Ontario government and OMA jointly agreed to regulate the growth in the number of physicians practicing in Ontario to preserve the opportunity to practice medicine in Ontario for graduates of Ontario medical schools and to improve the distribution of physicians and physician services. Source: Ontario, Ministry of Health, *1993 Agreement*

Between the Ministry of Health and the Ontario Medical Association (Toronto: The Ministry, 1993), p. 24.

[58] Ibid.

[59] Ibid., pp. 26-27.

[60] Approximately 600 physicians live and practice in "specified" communities whose population is less than 10,000 and which are more than 80 km from a major referral centre (defined as one whose population exceeds 50,000). All of these physicians are eligible to access the CME fund. For programs taken in year one of the program (1994), the fund will provide a maximum of $5000 per physician per year to cover registration fees, CME products associated with the course, travel expenses, income replacement assistance, accommodation and meals. In addition, a maximum of $500 per physician is available to purchase accredited CME products, including journal subscriptions, on-line literature or database services, self-assessment programs and CME software. For this and additional detail on the OMA CME program, see: Kathryn Harvey, "Continuing Medical Education: bridging the distance" *Ontario Medical Review* (January 1995): 39-40.

[61] *1993 Agreement Between The Ministry of Health and the Ontario Medical Association* p. 27.

[62] Rourke, "The politics of rural medical care: forces for change," p. 20.

[63] Telephone interviews with Dr. David Peachey, Director of Professional Affairs, Ontario Medical Association (OMA) and Janice Cousens, Manager, Continuing Medical Education (CME) Program, OMA, November 1994.

[64] Robert Sheppard, "Just what the rural doctor ordered," *Globe and Mail*, 24 January 1995, p. A19.

[65] Ibid.

[66] Information sent by David Salter, Program Manager, Northern Health Programs and Planning Branch, Ministry of Health on January 30, 1995. *Underserviced Area Program*, "Urgent placement locum tenens program for general/family physicians," p. 3.

[67] Ibid., "Respite placement locum tenens program for general/family practitioners" p. 1.

[68] Ibid., "Urgent placement locum tenens program for general/family practitioners," p. 3.

[69] Ibid., "Incentive grant program for physicians: guidelines," pp. 1-2.

[70] *1993 Agreement Between the Ministry of Health and the Ontario Medical Association*, pp. 5-6.

The threshold payments adjustments set out do not apply to:

physicians working in underserviced areas by arrangement with the Ministry of Health under the Ministry of Health Underserviced Area Program; or

where the Minister of Health determines, to physicians working in a particular geographic or specialty area. The Government agrees to consult with the OMA in developing guidelines for determinations under paragraph 11.2.

[71] Colin Muncie, "Rural docs go national," *Ontario Medicine* (October 1994), p. 5.

[72] Rourke, "Politics of rural health care: recruitment and retention of physicians," p. 1282.

[73] Ontario, Ministry of Health, "Emergency room doctors. . . meeting the needs of rural and small hospitals," *Final Submission to Fact Finder Graham Scott* (Toronto: The Ministry, February 1995), p. 2.

[74] Ibid., p. 1283.

[75] Ontario, Provincial Coordinating Committee on Community and Academic Health Science Centre Relations, "Health Human Resources and Emergency Health in Small/Rural Communities" *Newsletter* (PCCCAR Report No. 2 - October 1994), p. 2.

[76] Ontario, Ministry of Health, "Red Lake doctors agree to restore emergency medical coverage," *News Release*, 14 December 1994, pp. 1-2.

[77] Graham W.S. Scott, Q.C., *Report of the Fact Finder on the issue of Small/Rural Hospital Emergency Department Physician Service* (Toronto: Ontario, Ministry of Health, Ontario Hospital Association, 22 March 1995), p. 7.

[78] *Towards Integrated Medical Resource Policies for Canada*, p. 20.

[79] Charlotte Gray, "Managing the supply of MDs: opinion divided on ministers' proposal to develop a national plan," *Canadian Medical Association Journal* 151:10 (15 November 1994): 1477.

[80] Ontario, Ministry of Health, *1993 Agreement Between the Ministry of Health and the Ontario Medical Association* (Toronto: The Ministry, 1993), pp. 25-26.

[81] Rod Mickleburgh, "Ontario blocks new MDs," *Globe and Mail,* 4 August 1993, p. A1.

[82] Ibid.

[83] "Will Doctor Deal Help Northwest?" *Thunder Bay Chronicle*, 8 August 1993, p. A6.

[84] Ontario, Ministry of Northern Development and Mines, Ministry of Health, *Background Package re: Agreements Reached Between the Government of Ontario and the Ontario Medical Association*, Remarks by Michael Decter, Deputy Minister of Health to the Sudbury District Medical Society, 5 December 1991 (Toronto: The Ministry,

1991), pp. 2-3.

[85] An Interministerial Steering Committee and A Study Advisory Group were formed. The Steering Committee, comprised of representatives of the Ministries of Northern Development and Mines (MNDM), Community and Social Services (MCSS) and Health (MOH) provided the consultants with input, advice and direction throughout the course of their study. The Study Advisory Group, comprised of professionals, academics, and individuals knowledgeable about human resource issues in the North, served in a consultative capacity. Ontario, Ministry of Northern Development and Mines, Ministry of Health, Ministry of Community and Social Services, Peat Marwick Stevenson and Kellogg, *Recruitment and Retention of Health and Social Service Professionals in Northern Ontario: Summary Report* (Toronto: Peat Marwick Stevenson & Kellogg, 1992), p. 2.

[86] The Peat Marwick Stevenson & Kellogg study had the following 5 objectives outlined in the Study Terms of Reference on page 3. These were as follows:

(1) To describe the current status of health and social service human resources in Northern Ontario and to document past and current strategies and programs used to attract and retain health and social service professionals to practise in the North.

(2) To identify problems in recruiting health and social service professionals to work in Northern Ontario and to propose effective recruitment strategies.

(3) To identify problems in retraining health and social service professionals in Northern Ontario and to propose effective ways to better support, retain and develop health and social service human resources in the North.

(4) To examine how health and social service human resources available to the North could be utilized more efficiently and effectively.

(5) To evaluate the Northern recruitment, incentive and bursary programs and to recommend how such programs can be strengthened.

[87] Peat Marwick Stevenson and Kellogg, *Recruitment and Retention of Health and Social Services Professionals in Northern Ontario: Summary Report,* p. 17.

[88] Ibid., pp. 17-18.

[89] Ibid., pp. 18-19.

[90] Telephone interview with Tariq Asmi, Policy Consultant, Northern Health Programs and Planning Branch, Ministry of Health, 27 January 1995 at (416) 327-8316.

[91] *Toward Integrated Medical Resource Policies for Canada*, p. v.

[92] In the January 1995 issue of the *Ontario Medical Review*, Kathryn Harvey, Public Affairs Department wrote that "while there has been some governmental movement at the national level, much of the real work on developing practical solutions to identified problems is occurring within the medical profession itself." According to Dr. David Peachey, OMA Director of Professional Affairs, "the Association's corporate commitment to addressing physician resources issues has never been stronger." Physicians across the province have demonstrated a willingness to share their ideas and they are dedicating their energy in an effort to arriving at workable solutions. According to Dr. Peachey, "the OMA is well-suited to assuming an expanded role in the management of physician supply and distribution." Source: Kathryn Harvey, OMA Public Affairs Department, "OMA assumes expanded role in management of physician supply and distribution," *Ontario Medical Review* (January 1995): 33-4.